First Steps™
PEDIATRICS & ADOLESCENT MEDICINE

Authorization for Release of Protected Health Information

***Authorization to release my PHI is hereby granted to*:**

_____
Name of Facility or Physician

_____
Address City St Zip

_____
Telephone Number Fax Number

Records are requested for the purpose of (Provide a Detailed Description): _____

***Medical Records being released to*:**

First Steps Pediatrics & Adolescent Medicine, P.L.L.C.
3045 Pennsylvania Avenue Level 1
Weirton, WV 26062
Phone: (304)723-4000 Fax: (304)723-4003

Information regarding the patient named below:

_____
Name

_____
Address City St Zip

_____ _____
Date of Birth Social Security Number / MR#

Please Include The Following: Dates From: to:

All Records*		Discharge Summary		Growth Charts	
Lab Findings		Office Notes		History & Physical Notes	
Other Diagnostic test		X-Rays		Surgeries & Procedures	
Pap Results		Immunizations		***Justification**	

HIV, BEHAVIORAL HEALTH AND SUBSTANCE ABUSE INFORMATION CONTAINED IN THESE RECORDS WILL BE RELEASED THROUGH THIS AUTHORIZATION UNLESS OTHERWISE IINDICATED BELOW:
DO NOT RELEASE: __ HIV __ SUBSTANCE ABUSE __ BEHAVIORAL HEALTH/PSYCHIATRIC __ OTHER
I understand the following:
* That my health records will not be released or obtained by FSP unless permission is provided for herein as evidenced by the signature on this Authorization for Release of Protected Health Information.
*That the release of my health records will be for the purpose stated on this form, and only those items checked off will be released.
*That the Authorization is in effect for a period of 365 days unless a specific timeframe less then one year is documented.
*That I have the right to revoke this Authorization form at any time by sending a written request to the above listed facility/physician. My decision to revoke the Authorization does not apply to any release of my health records that may have taken place prior to the date of my request to revoke and may result in my insurance company not being able to pay for my medical care and I may be liable for payment of the claim.
* I am entitled to a copy of this completed Authorization form.

Signed_____ Date:_____
(Parent Guardian Self)